Camp Health Exam for Campers, Staff and Adults

Physical exams are valid for 3 years from date of last exam for those under the age of 40, and for 1 year for those 40 and over. A current school medical form may be substituted for this section.

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Name__________________________ Date of Birth ____/____/____ **Date of Exam** ____/____/____

_____ May participate in all camp activities
_____ May participate except for: ______________________________

____

Medical information pertinent to routine care and emergencies: ______________________________

Blood pressure: _____/__________ Pulse: __________ Height:: __________ Weight: ______

Is this individual taking prescription or over-the-counter medications? ☐ Yes ☐ No ______________________
If yes, please attach Authorization for Administration of Medication by Camp Personnel if not listed under Standing Orders, page 1.

Does this individual have allergies? ☐ Yes ☐ No Explain:______________________________
Please attach allergy treatment plan for severe allergies requiring medications

Does the individual require a special diet? ☐ Yes ☐ No Explain: ______________________________

Does the individual have special needs? ☐ Yes ☐ No Explain: ______________________________

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No	Had Disease		Yes	No	Had Disease
Measles				Hepatitis B			
Mumps				Diphtheria			
Rubella				Pertussis			
Chickenpox				Polio			
Tetanus *Date________							

Comments ____

____

Print name of medical care provider: ______________________________

Medical care provider's address: ______________________________
street *city* *state* *zip*

Doctor's Stamp

____
Signature of Physician, APRN or PA

____
Date signed

______(______)______
Telephone Number

Connecticut Rivers Council, BSA **Day Camp Medical Form**

NEW MEDICAL FORM PROCEDURES

- This side of the form is to be completed every year to ensure all information is current and correct.
- The Physical Exam on page 2 may be resubmitted up to 36 months from the date of the exam for those under age 40. Those leaders age 40 and older and over require an annual health exam.

____Staff ____Adult Leader Pack Number______________
____Camper Dates Attending______________

Name:____ Sex: M/F______ DOB:__________ Age:______
(last) (first)

Address:____ Phone: ( ) ____________ Child lives with:______
(street) (town) (state) (zip code)

Parent/Guardian Name:__________________________ Phone: ( ) ( ) ( ) .
(Home) (Work) (Cell)

Parent/Guardian Name:__________________________ Phone: ( ) ( ) ( ) .
(Home) (Work) (Cell)

If unable to reach parent/guardian, please notify:__________________________ Phone: ______________

Insurance Carrier:______________ Policy #__________ Group #__________ Primary Cardholder______________
(or attach a copy of the front and back of insurance card)

Health History

To be completed by Parent/Guardian

- Do you take any prescription or over-the counter medications? Y/N ______________________
  If any medications are needed at camp, please attach an ***Authorization for the Administration of Medication by Camp Personnel*** *for each, signed by parent and MD. (available at www.ctrivers.org)*
- Do you have any allergies to food/medications or other? Y/N Please describe substance, type of reaction, and treatment.
  ____
  Note: If medications are required for treatment of allergic reaction, please include allergy treatment plan, signed by parent and MD. (sample available at www.ctrivers.org)
- Chronic/Recurring Illnesses: *(please check)* Asthma_____ *(Provide MD treatment plan if severe.)*
  *Diabetes_____ *Epilepsy_____ *(*Requires physician treatment plan.)*
  Heart condition_____ High Blood Pressure_____ Abdominal_____ Mental health_____ Surgery_____ Other_____
  Please explain details of above.____
- **Date of last Tetanus Immunization:____/_____/_____**

Please carefully read the following: If you disagree with any statements here, please cross out that section and initial it. Explain your wishes in the comment section, attaching an additional sheet if necessary.

This medical form is correct so far as I know, and the person named in Part I has permission to **participate in all camp activities** except as noted on the form by me or on the reverse by the doctor.

In case of **accident, injury or illness** while at camp, I hereby give my permission to the doctor selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication.

I hereby request that the **prescription and/or over-the-counter medication(s)** ordered by my child's doctor/dentist be administered by the camp's Health Officer. I understand that I must supply the camp with the prescribed medication in the original container as dispensed and properly labeled by a doctor or pharmacist and will provide no more than is appropriate for my child's camp stay. I understand that this medication will be destroyed if not picked up within one week after my child leaves camp.

I also give permission for my child to **participate in trips** sponsored by the camp and approved by the adult/unit leader in charge. Examples of these trips are whitewater merit badge, orienteering merit badge or trips for rock climbing or mountain biking.

The Connecticut Rivers Council may take **pictures and/or videos** for use as camp promotional material for the camp and/or programs and I realize that my child's likeness and/or mine may appear in this material.

Signature:____ Date signed:____________________
(Adults over 18 sign here. Parent/guardian signs for camper.)

Name (print):____

Comment:____